March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period.* (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts the notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of the Employee Retirement Income Security Act of 1974, and the regulations thereunder (29 CFR 2520.104b–1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan (as defined in section 414(e)), the applicable federal agency is the Department of the Treasury. For a group health plan that is not a church plan, see 29 CFR 2590.712(h)(3)(ii). The notice must include—

(*1*) The name of the plan and the plan number (PN);

(*2*) The name, address, and telephone number of the plan administrator;

(*3*) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(*4*) The name and telephone number of the individual to contact for further information; and

(*5*) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset.* This section does not apply to benefits for services furnished on or after September 30, 2001.

[T.D. 8741, 62 FR 66953, Dec. 22, 1997]

§ 54.9831–1T Special rules relating to group health plans (temporary).

(a) *General exception for certain small group health plans.* The requirements of Chapter 100 of Subtitle K of the Internal Revenue Code do not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

(b) *Excepted benefits*—(1) *In general.* The requirements of §§ 54.9801–1T through 54.9801–6T, 54.9802–1T, 54.9811–1T, and 54.9812–1T do not apply to any group health plan in relation to its provision of the benefits described in paragraph (b)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar insurance;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan, as defined in paragraph (b)(3)(ii) of this section.

(ii) *Integral.* For purposes of paragraph (b)(3)(i) of this section, benefits are deemed to be an integral part of a plan unless a participant has the right to elect not to receive coverage for the benefits and, if the participant elects to receive coverage for the benefits, the participant pays an additional premium or contribution for that coverage.

(iii) *Limited scope.* Limited scope dental or vision benefits are dental or vision benefits that are sold under a separate policy or rider and that are limited in scope in a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefit packages.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed dollar indemnity insurance (for example, $100/day) is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) *Conditions.* Benefits are described in paragraph (b)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(5) *Supplemental benefits.* The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(ii) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as CHAMPUS supplemental programs); and

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(c) *Treatment of partnerships.* [Reserved]

[T.D. 8716, 62 FR 16939, Apr. 8, 1997; 62 FR 31670, June 10, 1997. Redesignated and amended by T.D. 8741, 62 FR 66952, Dec. 22, 1997; T.D. 8788, 63 FR 57556, Oct. 27, 1998]

§54.9833–1T Effective dates (temporary).

(a) *General effective dates*—(1) *Non-collectively-bargained plans.* Except as otherwise provided in this section, Chapter 100 of Subtitle K and §§54.9801–1T through 54.9806–1T, 54.9802–1T, and 54.9831–1T apply with respect to group health plans for plan years beginning after June 30, 1997.

(2) *Collectively bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Chapter 100 of Subtitle K and §§54.9801–1T through 54.9801–6T, 54.9802–1T, and 54.9831–1T do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). For these purposes, any plan amendment made pursuant to a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such Chapter, is not treated as a termination of the collective bargaining agreement.

(3)(i) *Preexisting condition exclusion periods for current employees.* Any preexisting condition exclusion period permitted under §54.9801–3T is measured from the individual's enrollment date in the plan. Such exclusion period, as limited under §54.9801–3T, may be completed prior to the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject